

Poliomyelitis Vaccination

SURGEON GENERAL LEROY E. BURNEY

IN 1958 there was more paralytic poliomyelitis in the United States than in 1957. The rates for paralytic cases were highest in 1-year-olds, and more than half of all paralytic cases occurred in children under 5 years of age.

Despite the high susceptibility of the Nation's preschool children, about a third have had no poliomyelitis vaccine. The total unvaccinated population under 40 years of age, including children and young adults, is more than 40 million.

These salient facts about the progress of vaccination against poliomyelitis were the subjects of a daylong discussion in Washington, D. C., in early December 1958. The meeting was called by the Public Health Service and was attended by representative State and city health officers and health educators and officials of the American Medical Association, the American Academy of Pediatrics, the Association of State and Territorial Health Officers, the National Conference of State Health Educators, the National Health Council, the National Foundation, the Advertising Council, Inc., and the Pharmaceutical Manufacturers Association.

The group agreed that the story of the Salk vaccine during the past 3 years is a truly remarkable one. More than 50 million persons have been vaccinated, and the incidence of poliomyelitis has dropped gratifyingly. Seldom, if ever, in the history of public health have so many persons taken advantage so quickly of a major preventive health measure. Seldom has there been a greater mobilization of health and medical resources, or a more intensive and sustained effort by official and voluntary organizations to accomplish a health purpose.

We have at hand a highly effective vaccine.

The 1958 poliomyelitis experience, to be described in the Communicable Disease Center's 1958 Poliomyelitis Surveillance Report, has provided additional evidence to support this statement.

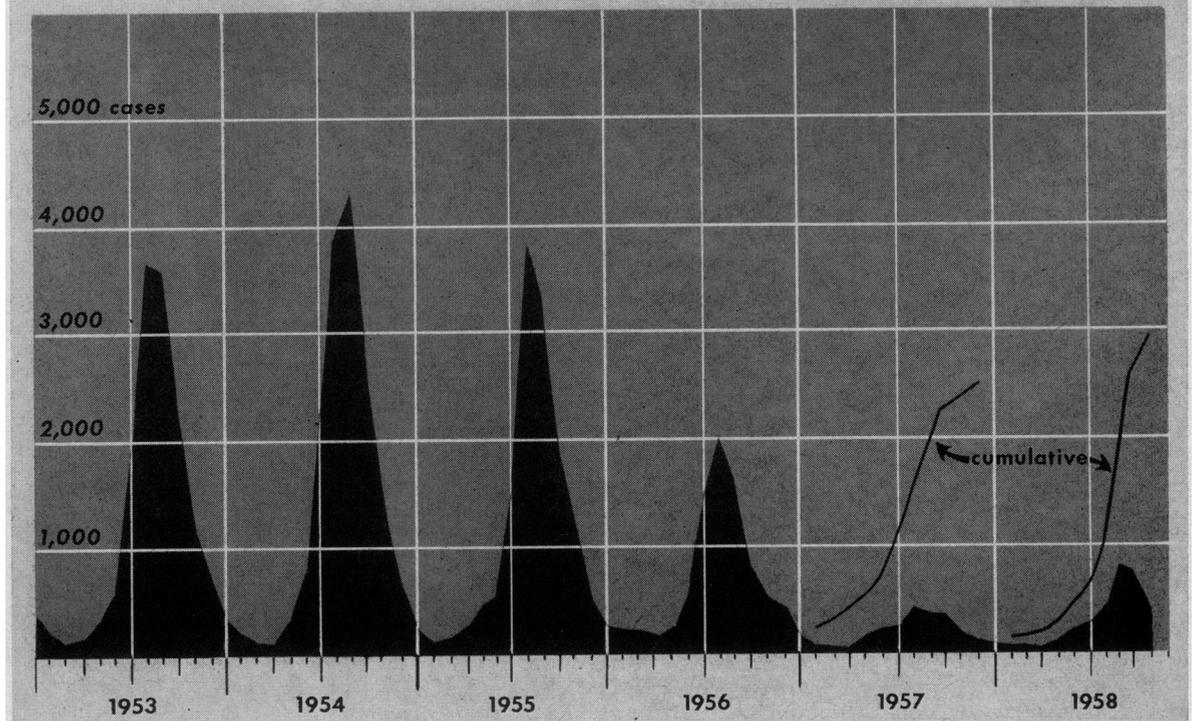
Yet the task remains to carry further the work of immunization. Although the Salk vaccine is not a 100 percent preventive and although the available data suggest that poliovirus continues to circulate even in well-vaccinated communities, it is evident that much of the paralytic poliomyelitis that occurred in 1958 could have been prevented if more persons had been vaccinated. It is equally clear that, by pushing forward with vaccination programs now, much can be done to reduce the number of paralytic cases that will otherwise occur in 1959 and subsequent years.

To translate what we know about a problem into effective action to solve it is, of course, one of the principal and never-ending challenges of society. Every health administrator is aware of the twin needs: to dispel ignorance and to overcome apathy.

Why have vaccinations lagged in the past 6 months? What means can be used to stimulate more people to seek vaccinations? These two questions were the chief subjects discussed at the Washington meeting.

The participants agreed that the primary responsibility for reaching the unvaccinated remains, as it always has, with the local community. Much has been done that can contribute to the accomplishment of the remaining task. The public is now widely informed about the vaccine, and professional people have gained valuable experience. These advantages, however, only partially offset the fact that the

Monthly Paralytic Poliomyelitis Incidence, 1953-1958



people who now remain unvaccinated are largely those who are difficult to reach with any health program. To get them vaccinated will require "face to face" campaigns under the leadership of local groups.

Surveys have demonstrated that many of the unvaccinated are in the lower socioeconomic groups. Reports from three of the 1958 epidemic areas stress this point. It is borne out, as well, by a sample survey conducted in Atlanta by the Public Health Service's Communicable Disease Center. It would be a mistake, however, to attribute the lag solely to economic reasons. Many communities, through local medical societies or public agencies, have offered vaccine free or at minimal cost during these past 3 years and found too few takers. Such factors as educational status, accessibility of clinics, simple fear of the needle, the human fault of procrastination, and, of course, indifference and apathy—all have a bearing. These and other problems are discussed in a paper by Rosenstock, Derryberry, and Carriger in this issue of *Public Health Reports*, pp. 98-103.

Undoubtedly the relative importance of the factors that interfere with acceptance of poliomyelitis vaccination varies from community to community. It is therefore important for each community to determine for itself what its chief problems are and how they relate to the current vaccination status in the various geographic sections of the city, such as census tracts or school districts. The resulting information then needs to be used to tailor the community's vaccination program to fit the local situation.

Professional health workers need not be reminded of how the process of acquiring this information can be used to enlist the active participation of physicians, agencies, and organizations in the vaccination program. It has been demonstrated many times that such groups work much more effectively throughout a program if they are consulted and utilized in the factfinding stage. By this device they are made to feel keenly their responsibility to do something about the findings that their studies reveal.

At the Washington meeting, the Public

Health Service announced that it was willing to help in this aspect of local community drives by lending to communities some of the technicians who carried out the Atlanta survey. I am glad to repeat that offer here.

The emphasis on local community responsibility is also explicitly set forth in recommendations unanimously adopted by the House of Delegates of the American Medical Association at the annual meeting on December 4, 1958. A happy coincidence of dates enabled us to provide the representatives at our meeting with a copy of the AMA resolution.

In brief, the recommendations are that (a) each physician assume responsibility for making sure that all members of the families he sees are fully vaccinated; (b) that State medical societies work with State health departments to bring county medical societies together with health departments to work out vaccination programs; and (c) that county medical societies meet with local health departments to survey local problems and devise ways to meet local situations.

In discussing the role of the local community with respect to poliomyelitis vaccination activities, I do not mean to suggest that the Public Health Service will not continue its efforts. We shall, of course, continue our surveillance and reference diagnostic services and continue to

offer assistance when epidemics threaten. In promoting vaccinations, we shall continue to conduct a program of public information and education through the States and in cooperation with national organizations.

We have asked again and have been assured of the assistance of the Advertising Council in a national campaign, to begin in the spring, of newspaper, radio, and television reminders of the importance of poliomyelitis vaccinations.

All the national organizations represented at our meeting have indicated that they will continue their national programs and will urge their State and local affiliates to do all within their power to make community drives a success. The National Health Council has also offered its assistance in working with other national organizations.

The new element introduced at the Washington meeting, in other words, was not a shift in the relative responsibility assumed by national, State, and local organizations but rather a shift in the way these efforts would be channeled. Until now, programs have been aimed principally at the general public. It is proposed now that in addition we seek to pinpoint our targets, finding as precisely as possible what segments of the population in each community have not been reached, and devising programs to meet their special needs.

Zero Tolerance for Aramite Established

The Food and Drug Administration has ruled that no residue of the pesticide Aramite is permissible on fruit and vegetables in interstate commerce. The new order, effective December 24, 1958, rescinds the previously established tolerance of 1 ppm.

The action was based on data from animal feeding studies, submitted by the manufacturer, which show that Aramite when fed at levels as low as 500 ppm causes cancer in dogs.

At the request of the manufacturer, and as provided by law, an advisory committee of scientists was nominated by the National Academy of Sciences and appointed by the Food and Drug Administration to consider the data from the feeding studies. The committee recommended the zero tolerance for Aramite.